Ann Hammi Blue, D.D.S., M.S., P.C.
Blue Periodontics and Implants
Diplomate of the American Board of Periodontology

Patient Name_____
Last *First* *MI*

Birthdate_____

Name of Referring Dentist_____

Medical and Dental History

To ensure your well being while undergoing treatment in our office, please answer the following questions with a YES or NO response and provide details for all YES responses. All information will be considered confidential and for our records only.

Have you *ever* had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	Bleeding Problem	☐	☐	High Blood Pressure
☐	☐	Heart Attack	☐	☐	Liver Problem	☐	☐	Low Blood Pressure
☐	☐	Shortness of Breath	☐	☐	Artificial Heart Valves	☐	☐	Hepatitis A B C
☐	☐	Anemia	☐	☐	Diabetes Type I or II	☐	☐	Organ Transplant
☐	☐	Artificial Joints	☐	☐	Venereal Disease	☐	☐	Rheumatic Fever
☐	☐	Cancer or Radiation Therapy	☐	☐	Asthma	☐	☐	Scarlet Fever
☐	☐	Chemotherapy	☐	☐	Prostate Problems (males)	☐	☐	Tuberculosis
☐	☐	Blood Thinners	☐	☐	Stroke	☐	☐	Epilepsy / Seizures
☐	☐	Swollen Ankles	☐	☐	Hemophilia	☐	☐	Emphysema
☐	☐	Fibromyalgia	☐	☐	Arthritis	☐	☐	Fainting
☐	☐	Glaucoma	☐	☐	Rheumatism	☐	☐	Headaches
☐	☐	Sinus Problems	☐	☐	Respiratory Disease	☐	☐	Smoking
☐	☐	Pacemaker	☐	☐	Cortisone / Steroid Therapy	☐	☐	Tumors or Growth
☐	☐	Thyroid Problems	☐	☐	Herpes	☐	☐	Psychiatric Care
☐	☐	Mitral Valve Prolapse	☐	☐	Excessive Thirst	☐	☐	Latex Allergy
☐	☐	Heart Murmur	☐	☐	Kidney Problem	☐	☐	AIDS / HIV
☐	☐	Blood Transfusion	☐	☐	Osteoporosis	☐	☐	Lupus
☐	☐	Chemical/Drug Dependency	☐	☐	Yellow Jaundice	☐	☐	Frequent Urination

Any other illness not listed above ? ☐ Yes ☐ No If Yes, please explain:_____

Comments:_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal

☐ Other drug allergies_____

Please list *ALL* medications you currently take or have taken in the last year. Please include vitamins.

Medication **Dosage** **Reason** **When Started**

1._____

2._____

3._____

4._____

5._____

Physician's Name _____ Physician's Address _____

Physician's Phone _____ Physician's Fax _____ Last Visit Date and Reason _____

Please answer the following:

Yes	No	
☐	☐	1. Have you been hospitalized in the last 10 years? Reason_____
☐	☐	2. Have you had any serious illnesses or operations? Describe_____
☐	☐	3. Have you been treated previously, or are currently being treated, for osteoporosis with Antiresorptive or Bisphosphonate drugs (i.e., Prolia, Fosamax, Reclast, Aclasta, Boniva, Actonel, Zometa, Aredia, or other Antiresorptive or Bisphosphonate drugs or IV Zometa or Aredia)? If yes, explain_____
☐	☐	4. Have you taken cortisone or steroids in the last 6 months? Reason_____
☐	☐	5. Have you ever been told by your physician that you need antibiotics for dental appointments? _____
☐	☐	6. Are you taking hormone replacement therapy? If so, list_____
☐	☐	7. Have you ever had any reaction to anesthesia? If so, list_____
☐	☐	8. Have you ever taken Fen-Phen or Redux? If so, when and for how long?_____
☐	☐	9. Do you currently smoke or are a past smoker? If so, describe_____
☐	☐	10. Do you need to premedicate for dental visits? _____

Women: Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No / Taking birth control pills? ☐ Yes ☐ No / Nursing? ☐ Yes ☐ No

Dental History

Reason for today's visit_____

Date of last Full Mouth X-Rays_____

Check if you have had the following:

☐ Bad Breath	☐ Bleeding Gums	☐ Clicking or popping jaw	☐ Dental Implants
☐ Loose teeth	☐ Shifting of teeth	☐ Receding gums	☐ Headaches
☐ Mouth sores	☐ Sensitivity to hot/cold	☐ Grinding teeth	☐ Gum boils/abscess
☐ Bite Change	☐ Pain when chewing	☐ Clenching teeth	☐ Trouble chewing

What concerns you about your mouth?_____

Are you happy with your smile? If not, explain_____

How do you feel about having a partial denture or denture (false teeth)?_____

Additional Comments:_____

Signature of Patient or Legal Guardian_____ Date_____

Doctor Signature_____ Date_____